ASSESSMENT AND SPECIFIC CONCERNS OF THE SEVERELY VISUALLY IMPAIRED STUDENT

Final Report of the Institute

June 26-27, 1975
Michigan School for the Blind
Lansing, Michigan

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Submitted by

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Panel of Blind and Partially Sighted Students

INSTITUTE PROGRAM

June 26 -

9:00 - 9:30	---	Registration and Coffee
9:30	---	Welcome
9:45 - 10:45	---	Presentation and Tour - Dr. Nancy Bryant, Superintendent, Michigan School for the Blind
10:45 - 11:45	---	Presentation - "Visual Functioning in Low Vision" - Dr. Roger Seelye, Optometrist
1:00 - 2:00	---	Presentation - "Anatomy of the Eye and Major Medical Problems" - Dr. John Dunn, Ophthalmologist*
2:00 - 4:30	---	Presentation - "Psychological Assessment of the Visually Impaired Student" - Patricia Hecht, Former Psychologist at Michigan School for the Blind

June 27 -

9:00 - 10:00	---	Panel of Blind and Partially Sighted Students - Mr. Lou Tutt, Assistant Principal, Michigan School for the Blind
10:15 - 11:45	---	Panel of Professionals Working with the Visually Impaired - Dr. Arselia Ensign, Instructional Specialist for the Visually and Physically Impaired, Special Education Services, Moderator Panel Members: Mr. Joel Anderson, Teacher Consultant Dr. Dena Gruman, Plymouth State Home Dr. Everett Hill, Mobility Instructor Mrs. Virginia Rainey, Plymouth State Home Mrs. Sherry Raynor, Parent and Pre-School Program Director Mrs. Gertrude Rose, Association for the Blind
1:15 - 3:00	---	Presentation - "Psychological Issues" - Dr. Mary-Clare Boroughs, Clinical and School Psychologist Film: Blind Child, Sighted Child
3:00 - 3:30	---	Summary and Evaluation - Dr. John Braccio, State Department Special Education Consultant, School Psychologists

*Dr. Dunn did not present at the Conference. His presentation is summarized in the report that follows.

INTRODUCTION:

What follows is a summary of presentations, developed from my notes and from the tapes we made at the Conference. For the most part the words of the presenters have been paraphrased, and in parts even the order has been shifted - to keep the quantity in hand, and to make the content readable. My apologies if I have omitted major points, or distorted meanings!

Mary-Clare Boroughs

BACKGROUND INFORMATION AND THE MICHIGAN SCHOOL FOR THE BLIND

Dr. Nancy Bryant, Superintendent

Severe visual impairment is a minority problem effecting .1% of the population. Of these 2/3 are educated locally. Traditionally on a national basis, large type classes have been in the public schools, while braille has been concentrated in residential settings.

At the Michigan School for the Blind there are now 247 students. Of these the majority are at the secondary level - and a total of 38 are "deaf-blind;" 55 have no sight; 154 are legally blind but have some usable vision; 38 are partially sighted.

In the past 5 years there has been a drop in enrollment in the same proportion as the decrease in all public schools. There has been an increase in multiply handicapped students from 91 in 1970 to 150 in the past year - or 61% of the school population. The effect is felt in ability of high school population where, for example, the average math level is now grade 3.2.

At the present time the State is studying services to the blind and deaf students in the State. There will be no dramatic release of students, but a change in direction has already occurred. The staff will be selected to deal with more complex diagnostic and prescriptive questions. It is hoped that this service can extend beyond the screening and placement needs at Michigan School for the Blind to include short term service to children from local school districts.

Q: Regarding cost to local districts.

Michigan School for the Blind is a free service, although local districts may assist students with travel expenses.

VISUAL FUNCTIONING IN LOW VISION - DR. ROGER SEELYE, OPTOMETRIST

A low vision exam covers the same areas as vision exams for the normal visual range - acuity, binocularity, pathology, refractive error, and, if possible, a subjective assessment. With low vision special aids may be used, but their applicability depends on ability, age and motivation. Psychological issues are critical. To use aids, the fact of visual loss must be accepted by the patient, and this takes at least a year. Patients with a loss have more difficulty if it is recent, and need emphasis on optimism to make best use of remaining vision. If a patient is using his loss to maintain dependency, he will reject visual aids. An aggressive attitude, an emphasis on ability and independence are needed.

Clinical visual findings are stated as: distance examined distance for normal full sight.

For example:

20/20 = seeing the normal 20' letter at 20'

20/70 = seeing the normal 70' letter at 20'

10/50 = seeing the normal 50' letter at 10'

20/70 to 20/200 is the range of low vision

At 20/70 the individual can read, work normally at a near working distance. He will have problems at a distance or blackboard. Actually, functional vision performance will depend on attitude, intelligence and/or maturity, and can be evaluated better by a teacher than the optometrist. Vision between 20/200 and 20/300 presents problems for reading and improving near sight can be critical. Legally blind applies to corrected, better eye 20/200 or worse or 20^{o} or less in the center

at the greatest diameter even if acuity is 20/20 (Ex. "tunnel vision"). 20/400 is a severe loss, 20/1000 - 20/2000 uses braille plus possible low vision aids.

Mislabeling does occur.

1) Charts do not measure fine enough - there is no testing between 20/100 and 20/200.
2) Two eyes may improve total vision.
3) Field problems may create an impairment that is significant, but not qualify as legally blind.

There is a problem because there is no standardized testing method.

Q: The function of nystagmus.

Nystagmus occurs secondary to a loss of central sight. The eye compensates for the loss by searching. It produces a very slow functioning reader - fixation and movement do not combine well. Nystagmus may increase with anxiety. Looking out the side may decrease nystagmus and improve vision.

Q: What about children looking close or at odd angles?

Children find their own best way. Looking close will not hurt. There can also be poor habits, however, so a good evaluation may be needed.

Q: Who is competent to help the low vision child?

Michigan has started to certify low vision specialists. There are now eight certified specialists listed with the Division of Services for the Blind. The school may ask for a low vision evaluation - <u>ask questions</u>, get the answers needed!

VISUAL SYSTEMS - DR. JOHN DUNN, OPHTHALMOLOGIST

The purpose of this section is to discuss various causes for limited visual function in the 0 - 25 year old age group. It is convenient to divide the visual function into four systems. (Refer to Figure 1) The "refractive system" consists of the cornea and lens. The "receiving system" consists of the various cells in the retina (including the visual receptors - rods and cones) and the choroid which is a nutrient layer for the retina. The "transmitting system" carries electrical impulses to the visual area of the brain by way of the optic nerve and optic nerve tracts. The "interpretation system" is in the brain itself. Problems can be due to various factors such as improper development (congenital defect), infection, injury, degeneration and dystrophy.

REFRACTIVE SYSTEM The cornea is made of fine fibers which criss-cross in a very precise manner in order to permit the ready transmission of light. If the corneal development is improper or the fiberous arrangement is disturbed then scarring and opacification occurs. This process can happen with dystrophic changes, corneal stretching as seen in congential glaucoma, and after infection (gonorrhea and syphilis).

The lens is also a fine-fiber filled structure. It stops transmitting and focusing light properly on the retina if the fibers aren't entirely healthy. Conditions noted here are congenital cataracts (lens opacification) and conditions associated with severe intraocular inflammation.

At times surgical and medical treatment can be instituted to improve vision when the cause is in the "refractive system." Corneal

transplantation and lens extraction are two such procedures.

RECEIVING SYSTEM The retinal cells must be precisely arranged to permit adequate vision. Retinal malformation, retinal degeneration and retinal inflammatory disease can cause destruction of this system.

The choroid can be the site for degeneration and inflammation. Without a healthy choroid the retina doesn't function effectively. Few if any therapeutic measures are effective for disease in this category. At times visual aids can be used to magnify the image coming to the retina and thereby permit some reading and limited distant vision.

TRANSMITTING SYSTEM The optic nerve leaving each eye has about 1,000,000 fibers each heading for a particular part of the back part of the brain. Conditions such as degeneration, dystrophy, inflammation (meningitis), asphysia at birth, accidents, brain tumors and maldevelopment can cause the optic nerve to stop transmitting.

This system, if malfunctioning, can seldom be helped by medical or surgical care. One noted exception is in the disease called glaucoma. This disease is due to excess fluid pressure in the eye. This causes damage to the retina and in particular to the nerve fibers as they leave the eye. Early surgical treatment can preserve and even help return some lost visual function.

INTERPRETATION SYSTEM Light (sight) information that reaches the brain must be integrated in various ways so that useful information can be the final result. Conditions causing malfunctioning include hypoxia (low oxygen level), injury, tumors, degeneration, syphilis, encephalitis (inflammation of the brain substance), lead poisoning, hydrocephaly, microcephally, mongolism, and mental retardation. It is said that 20/20 vision requires a 20/20 brain. This system is the least accessible to medical or surgical treatment.

CONCLUSION It must be realized that of the four systems noted here, only the refractive system can have any real hope for effective treatment. The other three systems (receiving, transmitting and interpretation) often have conditions which mean permanent and at times progressive loss of visual function.

of the eye are subsidiary the delicately adjusted dioptric apparatus, as well as the complicated nutrient, protective and motor mechanisms.

As will be pointed out in a subsequent volume,[1] the retina is to be considered as an outlying island of the central nervous system, to which it is

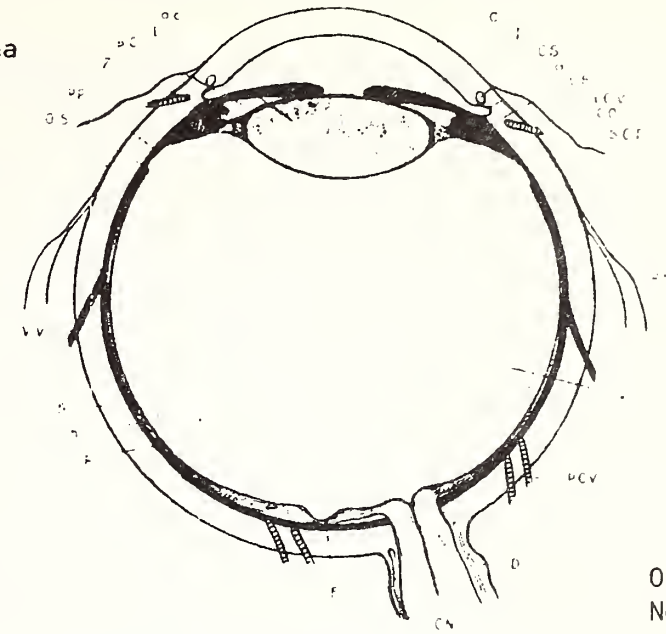

FIG. 63. DIAGRAM OF THE LONGITUDINAL SECTION OF THE HUMAN EYEBALL.

a. Angle of anterior chamber.
a.c. Anterior chamber.
a.C.V. Anterior ciliary vessel.
C. Cornea.
C.B. Ciliary body.
Ch. Choroid.
C.O. Ocular conjunctiva.
C.S. Canal of Schlemm.
D.S. Dural sheath.
F. Fovea.
I. Iris.
L. Lens.
O.N. Optic nerve.
O.S. Ora serrata.
P.C. Posterior chamber.
P.C.V. Posterior ciliary vessel.
P.P. Pars plana.
R. Retina.
R.M. Rectus muscle.
S. Sclera.
S.C.T. Subconjunctival tissue.
V. Vitreous body.
V.S. Vaginal sheath.
V.V. Vortex vein.
Z. Zonule.

connected by a tract of nerve fibres, the OPTIC NERVE. The nervous structure, as in the case of the brain and spinal cord, is encased within two coats serving the purposes of protection and nutrition. On the outside, corresponding to the dura mater, is a layer composed essentially of dense fibrous tissue which serves as a protective envelope, the FIBROUS TUNIC; the greater part, extending over the posterior 5/6 of the eye, is white and opaque, and is

[1] Vol. III. *Normal and Abnormal Development.*

PSYCHOLOGICAL ASSESSMENT OF THE VISUALLY IMPAIRED STUDENT

- - - - Patricia Hecht
(Former Psychologist at Michigan School for the Blind)

It is difficult to talk about tests because, among other things, the tests themselves are not readily on the market. The Hayes-Binet is no longer available; but the newer Parkins-Binet is not in print and may never be. The Maxfield-Buchholz Manual is not in print now, but will probably be available later. There's a reason for this. There are so few blind persons that it is difficult to standardize a test and then the market is so small that they are not readily picked up for publication. Tests are often available in experimental editions and you may have to push for that.

Another issue is that blindness is not a homogeneous category. There is a wide range of visual handicap. When you use visual test materials you may not be able to score them, but you can get useful information on how much the child sees, how he uses what he sees and so forth. Therefore, what is said here cannot ever apply to all visually handicapped students.

The psychologist also needs to be aware of the effect of the visual problem on the assessment. Age of onset is a question -- was this a handicap from birth? was it a recent event? (is there still anxiety, coping process?) If the child had vision to age 5 or more, there is visual memory available - an important asset.

You should know my biases. First I do not see a psychologist as a giver of tests. It is important to see broader contexts; to know what the child does in the classroom, at home. The psychologist

should talk to parents, see early records (what would the effect of multiple early surgeries be!). Parents and professionals tend to have one of two attitudes: 1) You can't expect much from a poor blind child - or 2) anything this child does is fantastic. In addition, partially sighted children may be expected to be like normal children. Parents are crucial - their attitude - the early experiences that give the blind child the initial start in life.

Secondly, my viewpoint is developmental. The critical question is not a diagnostic label or a test score, but where is the child now and what is the next step? How can you pull together what you learn, perhaps including tests, to give a teacher help on strengths and weaknesses and what to do next to help the child in his development.

What is our concern as school psychologists? Basically, we are looking at learning aptitude, ability to acquire symbols, an "ease of learning prediction." This is the need for the academic process. In a test you get bits and pieces the child may possess (reading vocabulary, math computation) and some indication of how he comprehends - how he uses what he has (reading comprehension, math concepts). The blind child - or the child with a severe visual handicap - has a special problem here. Vision is a simultaneous sense, it gives you details, even at a distance it gives you gestalt. Audition or words are only clues. Touch is always successive. Therefore, the child without reliable vision is limited in concept formation by the handicap itself. Range of experiences, ability to get around, control of the environment are all decreased. The visually handicapped child, then, has "unique

conceptual problems" - even concepts he may never comprehend - such as very large or distant objects (skyscrapers, moon and stars), liquids, minute insects, movement. This effects test responses. In vocabulary for example, when you ask "What is a juggler"?, you need to go beyond the first answer to see whether the child has more than words. These children need more concrete training, repetitive experiences with multiple opportunities to develop a concept.

This leads to my third bias. There should be no formal assessment of preschool children. You can apply standard tasks. Here at Michigan School for the Blind I almost never tested until a child was at least third grade and functioning well. The intelligence tests for normal children are verbal and limited as we have discussed. Furthermore, the blind child may be deprived in early development by an overwhelmed family which provides no exposure - no demands. And the totally blind child will not be able to learn by imitation -- as for eating, walking dressing. The child may learn passivly.

Q: Is language delayed?

There may be language problems. Echolalia is more frequent. These may be from environmental causes - lack of conversational experience. Blind children are also more egocentric, separate later. Multiple handicaps may also be present.

In looking for the appropriate test - in addition to the problems in verbal concepts and experience relating to known tests - the modalities by which the blind child learns are not well researched. We also do not have the predictive information from scores to school performance to predict academic success. Braille readers tend to be

one to two years behind, as are partially sighted print readers. One further issue is the pseudo-verbal child who may sound good, and score high verbally, but whose real level - socially, emotionally and intellectually is actually average.

When you do use a test, how can you judge the effects of what you modify? Was the sample adequate for the blind child? Do the components the test taps relate to the task of learning for the blind child? Is "compared to normal" meaningful?

In using tests to assess young children, one can select bits and pieces of tests: Bayley Scale, Hayes-Binet, Merrill-Palmer, WPPSI - for example. The child may not attend to the test - you need to assess what he does attend to -- people, things, sounds? Can you teach him a task that he does again later? How does he approach a problem? Is he motivated? If he is hyperactive, is it boredom? He may be delayed in motor development. He may ask repetitive questions (a kind of scanning to maintain contact). "Peaks and pockets" are typical for the visually handicapped child.

In the section that follows, tests were discussed one by one using videotape with comments (handouts and Wisland's chapter can supplement here).

Verbal Tests:

1) Hayes-Binet

The Hayes-Binet, while relying on the old Binet L and M, does have advantages in areas of meaningful memory and abstract reasoning. You need Braille sheets for Sentence Completion, Minkus Completion.

It is useful to fix your manual for efficiency. -- Note the "down time," which is common for a blind student. It is hard to know what is happening; is a response coming? - Digit Span may be spuriously high. It is recommended not to include Digit Span in the WISC verbal score for this reason. -- In Vocabulary, press for 8 consecutive failures.

2) Williams

This test is from England and not readily available. They use weight comparisons from the old Kuhlmann Anderson.

3) Wechsler

The handout on this is old. We do know that the scores for Comprehension tend to be the lowest for the visually impaired student, with Similarities next. Digit Span may be the highest. There is considerable within subtest scatter. The Wechsler may be preferable for the older student, where the Hayes is long and boring. It tends to be experientially loaded.

4) Performance Tests

In addition to the verbal tests, the Block Design is useful. For the blind student this means the Standard Kohs Blocks or the blocks from the Haptic Scale, even though these are only standardized for 15 years and above. There is information to gain on orientation to work space, approach to problem solving, use of practice item to item, use of hands, residual vision. (There is a Japanese version which is not satisfactory in design.)

I always give information to the student about materials or extraneous events - stop watch and so forth.

The Stanford is standardized for both blind and partially sighted, while the Haptic Scale is only for the blind.

5) The Blind Learning Aptitude Test

This test is exciting, but has not been published. It was issued in an experimental edition by the Printing House for the Blind.* It deals with differences, identities, progression, analogies, figure completion - using the tactile-kinesthetic mode. It does also ask for a verbal explanation of how the choice is made. It covers ages 6 to 14. The standardization was quite good.

6) Non Language Learning Test - starting ages 10 - 11. Mary Kay Bawman uses this clinically.

7) Haptic Scale

This test is roughly analogous to the WAIS performance scale. Block Design and Digit Symbol are useful. The abacus is not valid, since it is now taught in school.

8) Achievement Tests

The Wide Range can be adapted by making a braille version of the vocabulary and giving arithmetic and spelling orally.

The Stanford Achievement Tests (grades 2 - 9) are available from the Printing House in braille and large print. This is better administered as a power test - and does take a long time (2-1/2 times for braille!)

- In looking at achievement scores you will want to know what teaching the student has had.

The Stanford Tests of Academic Achievement (grades 10 - 12) are also available, as well as the Scholastic Aptitude Test for college entrance.

*Printing House for the Blind, 1839 Frankfort Avenue, Louisville, Ky. 40206

Another test is the Roughness Discrimination Test which is used to predict braille reading. This assumes highly developed tactile sensitivity (only mature by ten years).

Q: How about funds for special materials?

Quota funds might help - check your local district or write Michigan School for the Blind. Jackson Prison also transcribes braille at a minimal cost.

In summary, your testing needs to look for practical answers to questions being asked and to focus on assets as leads to the next step educationally.

Student Panel:

This face-to-face interview was not recorded.

We were most grateful to the students who shared their ideas and experiences with us. Mr. Lou Tutt of the Michigan School for the Blind staff was responsible for assembling this panel. During the hour we heard from students who have chosen to work out their educational plans in the normal setting and other students who have chosen the opportunities they feel they need at Michigan School for the Blind, after having checked out local school opportunities. Two students also described vocational training at MSB.

The Psychologist and Relationship to Fellow Professionals - Dr. Arselia Ensign - Panel Moderator

Panel: - Joel Anderson, Mary-Clare Boroughs, John Braccio, Nancy Bryant, John S. Dunn, Dena Gruman, Patricia Hecht, Everett Hill, Virginia Rainey, Sherry Raynor, Gertrude Rose, Roger Seelye, Lou Tutt, John Wallen, Students

Arselia: - You need the helpers. Teacher/consultants and psychologists are part of supportive services to visually impaired students. The first question for the panel is -- What do you want from your psychologist?

1) Sherry Raynor: - Parent and Preschool Program. Be people - act as person to person. Psychology is threatening to parents - need closer communication, personal understanding, not just scores. We need practical, meaningful help - the kind of help that comes from time spent observing the child. Parents should be seen at home to get a feeling for the situation. We want to know the strengths of the child.

2) Joel Anderson: - Teacher/Consultant, Secondary Level. Looking at my caseload of 12 partially sighted students, what is the best way to teach him - tactile, auditory, visual? How do we work with his problems to produce efficient skills? To assist him toward realistic goals? Secondly, I want information on his personality. What is his view on growth, change and independence? Can he be realistic? How does he see himself in relation to others? Help me see his problems, so I can help deal with it.

3) Trudy Rose: - Grand Rapids Association for the Blind. We have a cooperative program - skilled instruction,

preschool to college, for nonacademics, shared with the Kent Intermediate School District. We are interested in areas you can help with. What does the diagnosis of visual handicap mean? Can you tell us how he sees, under what conditions - physically and emotionally? Also - can you help us understand medication? What are its effects on behavior? Can you help the normal classroom teacher who takes these children into an integrated situation? We need your interpretation of scores.

4) Virginia Rainey: - Plymouth Center for Human Development Program for Visually Handicapped - 80 Visually Handicapped, 20 Deaf-Blind - All Retarded (SMI)

We need to know a lot qualitatively. We know our students as educated parents. We need to hear not infant scores for adolescents, but adaptive behaviors ... more than an IQ. The Vineland, perhaps the Denver Developmental Scale, best the AAMD Adaptive Behavior Scales. This gives a standard of described behavior. We have to look at the individual to know which handicap to use for placement decisions.

5) Dena Gruman: - Plymouth State Home

As a classroom teacher with visually impaired, help with child to school/teacher fit. You know the overall situation, the attitude of the school that will make the difference. You can help in the EPPC to gain the most productive placement for child opportunity.

As a teacher of the deaf-blind, the parents have great needs.

Many of the parents cope alone (only one out of 12 -- 11 had disintegrated in 4 years!) The parents need tasks with small increments and built in success. Parents are overwhelmed by stress on limitations pressed by professionals - limiting prophecies that held back the parents. What psychologists say are very influential on parents -- can have tremendous negative power.

With severely mentally impaired there are assets to be drawn out. You cannot predict if there has been past deprivation. You can estimate present, but note that you can't be accurate as a prediction for the future. This is especially true for the institutional child or the child who has had a succession of programs.

Arselia: - The panel can also share with us what they use in assessment.

Everett Hill: - In mobility - I'd like psychologists to get away from formal methods - and help teachers develop assessments. The teacher may have the observations, the content; you can provice the design, the strategy. The operational functional aspects of intelligence are what matter. There is so much "verbal unreality" (Cutsforth) in concepts. I have a performance test on positional concepts we can look at later - you can help us pin these needs down more.

Sherry Raynor: - Games booklet includes some of these questions.

Arselia: - Let's go on with assessment.

Sherry Raynor: - I'm just back from a conference on normal children -- and there is still a lot to learn on assessment even for

normal young children. That's how we feel with the pre-school blind too. Test scores may be meaningless. We use observation - the Maxfield Buchholz. We find teachers get lopsided without assessment of some kind; so we use bits and pieces -- Maxfield, Denver, the Boston Scale, measures we have made. This helps us stay in all areas in training. Teachers chose what they felt the child could gain that year, via strengths to work with from their observations. Our teachers are paying more attention to the why for a task - translating into practical skills for these kinds have so much to learn. This helps parents too - to teach the child in the real life situation - unpacking groceries, listening to calls - language and mobility are the central tasks. Psychologists have to help teachers and parents to understand the real life activities and gains that can be made that way. Most of our children are multiply impaired - we have a total of 40 children here - there are children out there too in your districts.

A Psychologist responds: - I don't have the luxury to take the time to do what you are asking. You are looking at us as Gods; we have many other areas in which we function. We're supposed to be specialists in so many areas, to see thus and so many children --- the pressure of numbers.

Sherry Raynor: - When you don't know, say so. Help us with the next small step.....

John Braccio: - There are pressures in the field .... We may need to continue on this - with continuing inservice, develop needs from this conference.

Arselia: - Mrs. Rose, can the community help us?

Trudy Rose: - We have developed a mobility program, and pressed for this in schools; we paid for the program up until the last two years. Now the school district is taking over - and we've added a second mobility teacher to work with preschool. We now have had a pilot project with a "rehabilitation teacher," and we are developing a shared project here. If you have United Way and you can interest an agency, it can be done.

We program for non-academic skills. There isn't enough time in the whole day. These are the skills for living that are so important.

Everett Hill: - Concept development - as tested in the area of position concepts for mobility -

(VIDEO TAPE)

Note that these terms are repeated and developed - and partial testing may not show up the problem. In addition, many spatial concepts are ambiguous. For example, near and far are relative - depend on the individual.

Parts: 1) Self - body parts

2) Self in environment, self-to-object

3) Object-to-object

Q: What do you start with? Preschool for example.

Self - body parts - and how they relate. Then objects themselves and self in relation to body.

Q: What about deaf-blind?

Performance is what matters more than whether they can tell back.

Psychological Issues: - Dr. Mary-Clare Boroughs

First, just a few words about personal attitudes. We all have a set about blindness that affects how we perceive the blind student. These include an expectation of passivity, a view of blindness as a "missing piece" rather than a whole of less parts, stereotypes of darkness and depression. As we approach a blind person we also deal with our fears of personal failure ("will I do the right thing?") in a situation and our needs to be helpful as contrasted with a more relaxed personal contact. We need to be aware of these attitudes and to try to overcome them.

Developmental concerns is a topic that has been touched upon repeatedly. We have a film showing some early developmental differences that I want to discuss briefly first. The basic fact that effects all of this area is that the normal child develops primarily in relation to visual stimuli -- holding up his head, reaching, grasping, walking -- all of these are in response to the visual world. Except when constantly stimulated by the other senses, the blind infant does not hold an awareness of not-self until much later at the stage of object constancy (9-11 months). Then with object and sound constancy developed, he may move out more on his own.

The effects of this are seen in poor gross and fine motor development. The blind infant has a long egocentric period and this leads readily into self-stimulating activities, the so-called "blindisms" as well as a tendency to passivity.

In addition, the socialization of the child, which is also lacking in the visual input, may be further hampered by family stresses. In

addition to possible fears regarding prematurity, guilt and anger, lack of information on ways to help the child and the lack of feedback from the child play a role.

As the child emerges from early infancy, another important aspect of the learning process is absent for the blind child; imitation is primarily a visual skill. Thus, early experiences of chewing and eating, walking, dressing, must be taught in other ways.

Pat Hecht and others have made the point about concept development. There is a dearth of good material on psychological adjustment in elementary and secondary years, but studies show the blind are "better adjusted" than the partially sighted. I feel that is an artifact of the way comparisons are made and the expectations placed on partially sighted (to fit in the sighted world) versus blind (to be dependent). It is certainly clear, from my contacts with adolescent blind, that the issues of becoming realistic, independent adult present many more hurdles of blindness of self, of parent or of society - that intensify and prolong the adolescent process, if the fully blind person is to become psychologically adult.

Film: "Blind Child, Sighted Child"
Child Development Project
University of Michigan
Ann Arbor, Michigan (313/764-9328)

(This film is free. There are other films and video tapes available.)

While our time is short, I have some video tapes showing assessment sessions with blind multiply handicapped young children. A word about blindness as a multiple handicap. Since the optic nerve is very

close to the brain, there are some causes of blindness that may also cause brain damage - a virus traveling in one direction or the other, for example. In addition, what damages eyes, may also damage the brain - such as prematurity. Rubella may have caused multiple handicaps, especially deafness, as well as blindness. There are also syndromes, developmental defects, which tie in with a visual handicap. If you know the child's diagnosis, that may be helpful. Since some multiple disabilities are life-long, and others may be milder and be overcome, there is a likelihood that a blind child with perplexing development is dealing with more than the primary handicap -- which may or may not respond to special training.

In assessing the multiply handicapped child, it is obvious that the more complex the handicap, the more difficult a "true assessment" may be - if you are thinking in terms of ultimate potential. However, I feel that some assessment with the bits and pieces that can be applied to a given child can be useful for several reasons.

1) With the close cooperation of the teacher you can get baseline data to tell you what the child can do, where gaps are, what he may need. Both over and underestimation are common with teachers (and parents), and a psychologist, with some standardized norms in relevant or trained areas, can help with basing plans on reality.

   In this area -- you have to help plan a program that can be implemented with what is the best available locally. You may have to place a blind-deaf environmentally deprived seven-year-old in a pre-school trainable class with the knowledge

that there is no way to attach a static label on that child. The concern over premature labels should not prevent us from making the most useful placement for that child in his present state of development. Children with several sensory handicaps cannot function at full normal levels.

2) Although we need to be wary of the relevance of what we are measuring, a baseline assessment will help us to chart progress realistically over time.

3) I like to get in touch with the child. More often than not, the referral problem becomes clearer as I interact with a child and find out what aspects of his behavior are puzzling and/or frustrating.

VIDEO TAPES

A) Normal, verbal, totally blind four-year-old with a balance problem and poor fine-motor coordination. - Note inadequacy of WPPSI items.

B) Totally blind, cerebral palsied, nonverbal seven-year-old - retarded, autistic behaviors. - Note egocentricity, intermittent constancy (?)

C) Partially sighted, nonverbal four-year-old performing with some use of vision, inconsistent, probably at 1-1/2 - 2 year level. - Note use of behavior modification (food reward) in testing and its pronounced effect. Note play behaviors - good sign, but egocentric interests.

EVALUATION

Summary of Scores	(SA	A	U	D	SD)
	5	4	3	2	1

1. 4.18
2. 4.42
3. 4.18
4. 4.29
5. 3.91
6. 4.05
7. 3.62
8. 4.14
9. 4.55
10. 4.14
11. 4.05
12. 3.71
13. 4.37
14. 3.21
15. 4.26
16. 4.25
17. 4.21
18. 3.55
19. 3.95
20. 3.45
21. 4.64

EVALUATION: Institute on Assessment and Special Concerns of the Severely Visually Impaired Student

To aid us in the evaluation of this Institute, please complete the following statements: Circle the letters that best reflect your feelings.

SA - Strongly agree
A - Agree
U - Undecided - or neutral
D - Disagree
SD - Strongly disagree

Feel free to add comments as they come to mind!

I learned new material in the Institute sessions as follows:

1) Role of the Michigan School for the Blind

SA A U D SD

Comments:

2) Vision and Visual Functioning:

SA A U D SD

Comments:

3) Psychological Tests:

SA A U D SD

Comments:

4) Contact with Visually Impaired Students:

SA A U D SD

Comments:

5) Discussion of Assessment as it Relates to Other Disciplines and Their Needs:

SA A U D SD

Comments:

6) Information Regarding Development:

SA A U D SD

Comments:

7) Information Regarding Multiple Handicap:

SA A U D SD

Comments:

The new material I learned can be useful to me in my work in assessment and consultation on visually impaired students.

8) Role of the Michigan School for the Blind

SA A U D SD

Comments:

9) Vision and Visual Functioning:

SA A U D SD

Comments:

10) Psychological Tests:

SA A U D SD

Comments:

11) Contact with Visually Impaired Students:

SA A U D SD

Comments:

12) Discussion of Assessment as it Relates to Other Disciplines and Their Needs:

SA A U D SD

Comments:

13) Information Regarding Development:

SA A U D SD

Comments:

14) Information Regarding Multiple Handicap:

SA A U D SD

Comments:

15) I felt material was adequately presented:

SA A U D SD

Comments:

I wanted more time for:

16) Subject Matter Presentation:

SA A U D SD

Areas?

17) Discussion between presenter and school psychologists:

SA A U D SD

Areas?

18) Direct Contact with Assessment Techniques:

SA A U D SD

Areas?

19) I felt I had a chance to ask questions formally or informally and that my questions were adequately answered:

SA A U D SD

Comments:

20) I feel I need more training in assessment procedures before I can use them:

SA A U D SD

Comments:

21) I would be interested in a follow-up Institute with a hands-on approach using a variety of assessment techniques:

SA A U D SD

Comments:

Scores on the evaluation fell primarily in the agree (A) category - with only slight variations in the score averages. Questions regarding new material (1 - 7) showed greatest gain in vision and visual functioning and least gain in multiple handicap. Questions regarding the usefulness of material (8 - 14) showed greatest strength and weakness in the same two areas - vision and visual functioning versus multiple handicap. Response to the question on adequacy of presentation was among the more positive scores. Need for more time (16 - 18) stressed the need for presentation and discussion over direct contact with assessment. Participants were apparently quite satisfied with their chances to ask questions and feel they can in some way use procedures without further training but showed considerable interest in a follow-up hands-on conference.

Summary of Participant Comments:

Many of you made useful comments. Your overall reaction was very positive. The most common comment was - "not enough time here" - and that comment applied to every area on one page or another.

In responses regarding the School for the Blind there was no argument with the current trend. Psychologists mentioned short term placement, vocational training and particularly the possibility of an assessment center that would provide a back-up to the local district.

There was some frustration with the lack of the ophthalmologist's presentation, especially the medical information he could have provided. Educational implications of the visual state were also mentioned. Questions regarding psychological testing brought forth concerns regarding the lack of available special instruments. Several participants requested more specific recommendations for subtests that could be used. Live demonstrations were requested. There was some interest in making the connection between test results and recommendations for classroom use.

In relation to other disciplines, the comments regarding time held true - with an urge for more communication. One participant noted that recommendations for improvement were the same that other areas make (L.D., etc.) and we psychologists do need to change!

It was in the area of developmental issues that the most comment was forthcoming. This should perhaps have come earlier in the conference, or had more time. The Fraiberg film was singled our as useful.*

*"Blind Child, Sighted Child", Child Development Project, University of Michigan, Ann Arbor, Michigan (313/764-9328).

More information on milestones, concept development and the difference between congenital blindness and later onset were mentioned.

The area of multiple handicap was stressed as an area for further information. Blind-deaf, blind-retarded, and blind-deaf-retarded were mentioned.

Although the group supported the presenters, there were a number of comments indicating that there was a need for more direct contact with the presenters and participants through other means than those available. Some discussion arrangements Thursday evening, better contacts at the motel, small group sessions were also mentioned.

Finally, there was a clear request for a further hands-on conference, perhaps to include preschool and multiple handicap, as well as school age visually impaired and stressing not only assessment itself, but also prescriptive implications.

Commentary:

One of you ended your evaluation with the comment that you felt the area required special ties among school psychologists. That leads to my own state of mind as I digested the content and the meanings of our two days together. Soon after the conference I wrote a letter to John Braccio sharing some of these thoughts, with copies to Nancy Bryant and Arselia Ensign.

First of all, I feel that it is quite possible to use one's own judgment (with the cautions we all heard regarding rate of general development and conceptual difficulties) on students where there are only minimal concerns (if indeed those students are even referred.)

Several of you mentioned the fact that you see so few blind students that there is no way to improve your assessment skills. Add to that the problems surrounding lack of available instruments and normative data regarding relationships, such as academic expectations, given current data on tests for normal students and the problem is compounded.

It is my recommendation that local psychologists and/or Regional Diagnostic Service psychologists should be acquainted with the issues of assessment of blind students, even to the point of a further hands-on conference for a selected group representing service points around the State. But it does not seem reasonable to expect psychologists in districts with minimal numbers of blind students to be able to become competent specialists with a battery of specialized materials.

Therefore, the role of the School for the Blind for short term assessment and prescription becomes clear.*

*If the MSB cannot develop this, can it be located elsewhere in a populated area or through RDS?

In my time there and over the past two years as psychologist to the deaf-blind diagnostic classroom (a five-week assessment placement), as well as in my experience with the Regional Diagnostic Service in this five county area, I have noted what might be the ingredients of such a service. There would need to be competent specialists from several disciplines drawing together the best available data on the medical, psychological and educational status of the child -- with the development of a prescriptive plan - and the staff to follow-up that prescription in the local district, to make the connection between the experience of the MSB diagnostic team and those attending the EPPC who must implement that plan locally.

Another of you mentioned the problem that occurs when college professors lose track of what happens at the local level. By the same token, specialists can lose touch with normal children, and the recommendations from such an assessment will need reworking to fit the real world. Here again the local psychologist, with the norms applied to normal children, can remind the specialists of the realities of who is taught and what is learned in the regular classroom and assist the EPPC to make reasonable placements in your local district.

Mary-Clare Boroughs

Chief Instructor

NOTE: Copies of handouts from the conference are not included here. Questions regarding these materials may be directed to: Mr. John W. Wallen, Ingham Intermediate School District, 2630 West Howell Road, Mason, Michigan 48854